Volume 4 - Quality Management and Grievance & Appeals

Proposal for Behavioral Health Services for Greater Arizona

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Table of Contents

a.1) Quality Management Function and Structure 1
a.2) Performance Improvement Model 3
a.3) Stakeholder Involvement 5
a.4) Accreditation and Contract Fulfillment 7
a.5) Communication of Quality Management Information 9
a.6) Using Information to Identify Improvement Areas 11
a.7) Timeliness and Completeness of Data 13
a.8) Process and Focus of Provider Monitoring and Performance Improvement Activities 15
a.9) Utilization Management Function and Structure 17
a.10) Utilization Monitoring 21
b.1) Notice Requirements 23
b.2) Grievance and Appeals Function 25
b.3) Grievance and Appeals Process 27
b.4) Grievance and Appeals Rights 32

a.1) Quality Management Function and Structure

This proposal is being submitted by the Greater Arizona Behavioral Health Authority, LLC (GREABHA), which has been established by Cenpatico Behavioral Health™ LLC (CBH), a managed behavioral health subsidiary of Centene Corporation® (Centene), to administer the contract in Arizona. Quality Management (QM) is the culture of all of the organizations in the Centene family of companies and is built into all aspects of GREABHA's operations including recruiting, contracting, coaching staff, and management. The QM department is responsible for establishing measures of excellence, monitoring progress toward achieving excellence in those measures, researching and promoting best practices, and infusing a culture of continuous quality improvement throughout GREABHA's departments and provider networks. The QM department's activities cover GREABHA and the service delivery system, and promote adherence to the Arizona System Principles, the Arizona Children's Vision and Principles, and Principles for Persons with Serious Mental Illness (Arizona principles). The QM Committee will:

- Assess and improve behavioral health recipients' access to care
- Assess and improve behavioral health recipient and family member involvement in the process of care
- Promote collaboration with the greater community, working closely to get input from all stakeholders including general medical, child welfare, criminal justice, education, and other social service providers, behavioral health recipients, and their family members, and providing regular feedback and data to the ADHS/DBHS QM/UM Committee
- Assess and improve behavioral health practitioners' use of best practices, including improving treatment for substance abuse disorders, and including increasing the involvement of behavioral health recipients and their family members in the process of care
- Work collaboratively with providers to disseminate processes and expectations for continuous quality improvement, creating a culture of quality throughout provider organizations and GREABHA's own staff
- Perform root cause analyses to identify barriers to successful implementation of the Arizona principles
- Assess and improve the cultural competency of the behavioral health care system, including ensuring that consumer rights are protected throughout the system

The QI process is coordinated through the QM department. GREABHA will maintain a QM Program and Annual Workplan that require monitoring, reporting, and performance improvement activities. The Workplan establishes areas of focus for quality improvement activities, along with specific quantifiable measures of quality in each area of GREABHA's operations, and a minimum threshold, goal, and benchmark level for each quantifiable measure. Improvement plans are implemented and monitored to address areas that do not meet threshold, goal, or benchmark, with the goal of continuous improvement on all targeted measures.

Throughout GREABHA, each department reports their quality indicators to the Quality Management Committee (QMC). The QMC is also charged with monitoring and evaluation of patient and practitioner confidentiality issues, and with monitoring and evaluation of patient safety issues. Most committees supporting the QM program are interdisciplinary in nature. This structure is designed to promote collaboration, coordination, and communication across disciplines and departments within the organization, with emphasis on integrating administrative activities, quality improvement activities, and clinical operations. The QMC provides an objective, systematic and continuous process for assessing, monitoring and improving the quality of behavioral health services provided to enrollees. Specific subcommittees and staff supporting the work of the QMC include the Credentialing Committee, Training Committee, Network Management Committee, Utilization Management Committee for higher levels of care, Consumer Advisory Council and Community Advisory Councils, Emergency Response team, Compliance department, Claims department, and Consumer Outreach department. The Quality Management program will be supported by staff at all levels of the organization as shown in the table below.

Position Title	Responsible for:	Reports To	GSA 1 # of FTEs	GSA 2 # of FTEs	GSA 4 # of FTEs
Chief Executive Officer	Monitors the quality improvement (QI) process; implements QI activities; Fosters a culture of QI throughout the organization	CEO of CBH	1		
Chief Medical Officer (CMO)	Provides leadership, direction, and guidance for all clinical aspects of GREABHA's operations, including the QM program, the utilization management program, and credentialing activities that involve providers	CEO of GREABHA	1		
Chief Officer of Community and Consumer Affairs	Maximizes collaboration and feedback from behavioral health recipients, family members and community stakeholders to provide a rapid and responsive communication loop between GREABHA, behavioral health recipients and community.	CEO of GREABHA	1		
Cultural Expert	Identifies and implements programs in an effective, understandable, and respectful manner compatible with recipients' cultural health beliefs, practices and preferred language. Recommends to EMT how to best employ, retain and recruit diverse staff and leadership that are representative of the demographic characteristics of the service area and that meet all 14 CLAS standards of cultural competency.	CEO of GREABHA	1		
Clinical and Provider Services Administrator (CPSA)	Oversees all clinical operations including technical assistance, problem resolution, customer service program administration, and provider contracting. Integrates contracting, training, technical assistance and monitoring into one department, to uniformly maximize compliance with the Arizona principles.	CEO of GREABHA	1		
Clinical Operations Administrator	Oversees clinical program development, personnel and services to children/ adolescents, adults with serious mental illness, adults with substance use disorders and adults with general mental health conditions. Oversees vocational/employment, housing, & prevention service	CPSA	1		
Quality Management Administrator (QMA)	Implements QI program, including chairing or co-chairing (with the CMO) the QMC	CMO	1		
Grievance & Appeals Administrator (G&AA)	Handles all grievances or appeals that are received by GREABHA.	QMA	1		
Grievance and Appeals Coordinator	Enters all data from complaints and grievances into data base; monitors timeliness for resolutions	G&AA	1	0.5	0.5
QM Coordinator	tracks data and routine reports, maintains meeting minutes, and updates and maintains a log of policies and procedures	QMA	1	0.5	0.5
Data support	Prepares the required reports for the QM Dept. which will allow the GREABHA to monitor overall effectiveness of program	QMA	1	0.5	0.5
Consumers and Families	Participation at the highest levels of decision making through consultation with the CEO on the Consumer Advisory Board, and also through participation on the QMC	CEO	2+	2+	2+
Provider Training Staff	Communicate QI objectives and implement actions in collaboration with provider agencies, to achieve quality program goals	QMA	2	1	1

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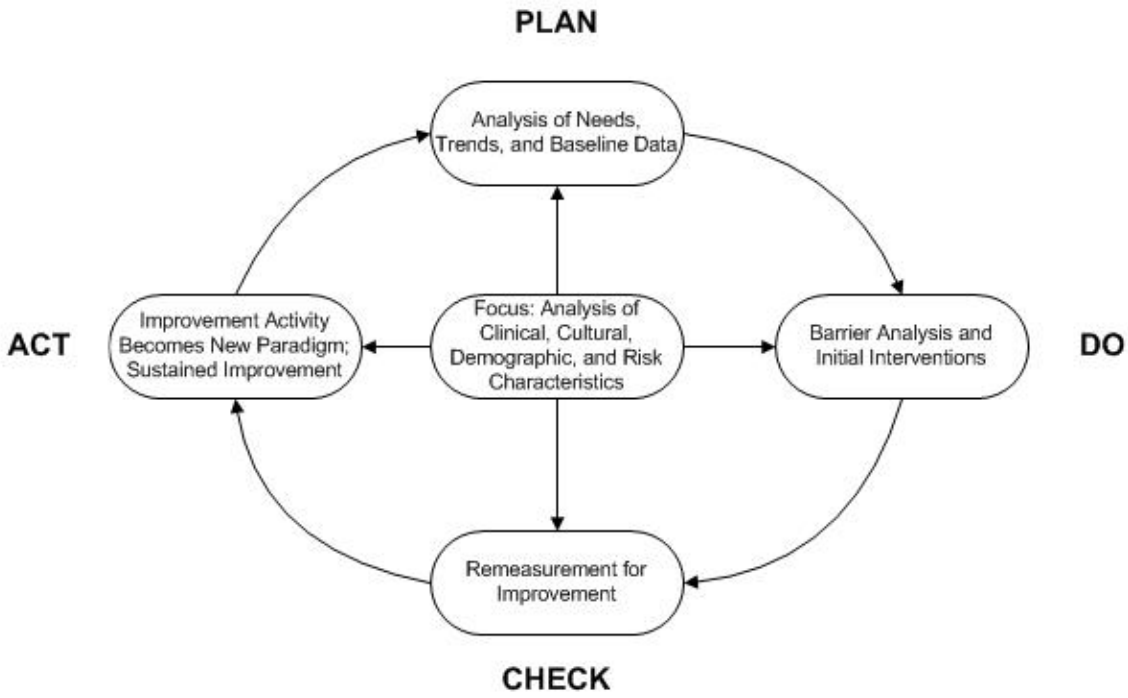
a.2) Performance Improvement Model

GREABHA's proposed quality improvement activities are designed to increase adherence to the Arizona principles by the behavioral health service delivery system, including improving clinical quality in the treatment of acute and recurring psychiatric and substance abuse conditions and promoting efficient, timely, and accessible delivery of behavioral health services to Arizona behavioral health recipient and families.

GREABHA's performance improvement model involves (a) monitoring and (b) evaluating the service delivery system in order to promote improvement in the quality of care to behavioral health recipients. In cases where an opportunity for improvement exists (based on current levels of performance not meeting ADHS/DBHS goal or benchmark), a quality improvement action plan is initiated. The Quality Management Committee (QMC) monitors and oversees progress on all action plans, and prioritizes QI action plans based on local business needs when competing resource needs mean that all QI action plans cannot be addressed at once. In rare instances where a performance indicator does not meet the minimum necessary standard required by ADHS/DBHS, an immediate action plan is initiated, and progress is monitored on a very intensive basis (e.g., weekly or daily) until the quality problem is resolved. In cases where the quality improvement activity is initiated in order to improve performance beyond the minimum necessary standard (i.e., to meet a goal or benchmark), then the QMC will monitor progress on the action plan at least monthly and reexamine data on a predetermined schedule with equal measurement intervals and an adequate follow-up interval to ensure sustained improvement (e.g., not simply a seasonal variation).

GREABHA uses the Focus-Plan-Do-Check-Act (Focus-PDCA) process to support the Arizona principles:



Focus—Population Analysis

- GREABHA routinely collects and interprets information from all parts of the organization to identify areas of concern, clinical issues, and behavioral health recipient service issues. Information used for selection of activities may include consumer satisfaction data; consumer or practitioner complaint data; information about the population's demographic, clinical, cultural, and risk characteristics; utilization and outcome information; or external data

sources. Data also may be compared to external benchmarks or best practices to establish quality goals.

- GREABHA quality improvement projects must focus on behavioral health recipient, must relate to one or more of the quality measurement areas described in Section 4.a.6, and must evaluate improvement using quantifiable measures, data collection methods, and measurement designs that are statistically valid and reliable. For all quality improvement projects that are focused on improving behavioral health recipients' clinical care or functional status, including clinical services, community-based services, and other behavioral health support services, a clinical staff person is designated with responsibility for the project, and consults with the Consumer Advisory Committee, the Community Advisory Committee, and CBH's national practitioner advisory committee of behavioral health experts to obtain feedback, if applicable.

Plan—Baseline Data Analysis

- Once an area of potential concern is identified, a specific study question is stated. Study questions must ultimately focus on meeting GREABHA behavioral health recipient' needs in clinical or service delivery areas. In some cases, an activity focused on improving practitioner satisfaction may also be appropriate.
- Baseline data are collected. If a new data source is developed for use with a QIA, steps are taken to field-test and validate the data collection methodology prior to drawing conclusions based on the data.

Do—Barrier Analysis and Interventions

- Using the baseline data as a guide, the QMC identifies barriers to implementing the Arizona principles or factors that may be interfering with the achievement of quality program goals, and opportunities for improvement that are related to these barriers. Barriers will also be reported to the Community Advisory Councils, and if system-related, to the Executive Management Team for further consideration and direction.
- Based on this barrier analysis, the QMC designs and implements strategies and actions to improve performance on the relevant quality indicator(s). These action plans are tracked through the QMC.

Check—Re-measurement and Analysis of Improvements

- At the time that interventions are begun, a target timeframe is set for reviewing progress and for an expected improvement in performance. At that time, the QMC evaluates the effectiveness of the interventions implemented and identifies any additional barriers that may be interfering with the achievement of performance goals.
- If additional data become available during the course of the QIA, these data are presented to the QMC and to the Consumer Advisory Councils and Community Advisory Councils in order to design additional interventions as appropriate.

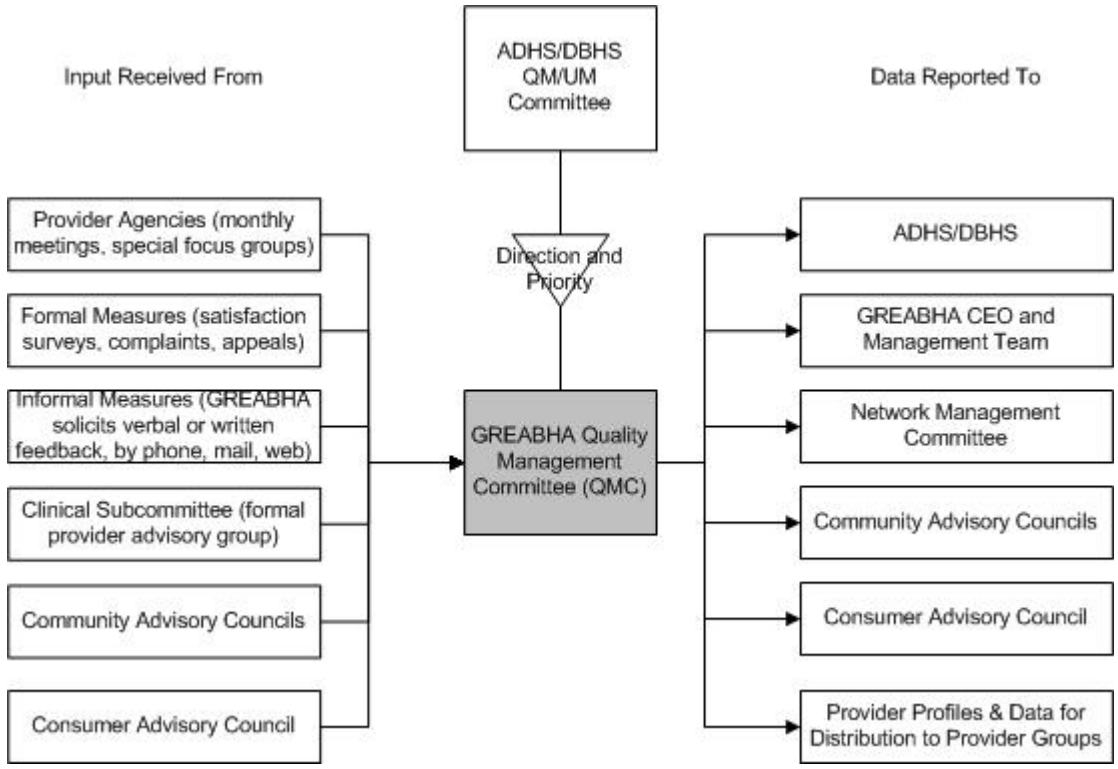
Act—New Processes Become Part of Operations for Sustained Improvement

- Re-measurement is conducted at periodic intervals. If an improvement over baseline is noted, the QIA may be closed after ensuring that the improvement is sustained for an appropriate period of time (the length of time depends on the specific activity and measures. In some cases, as little as one quarter may be enough to show sustained improvement; in other cases [e.g., measures that show seasonal trends] a year of sustained improvement may be necessary).
- If there is no improvement, additional interventions and actions are designed. If there is partial improvement, the QMC revisits the activity to determine whether additional interventions will contribute to additional improvement.
- GREABHA intends to frequently use collaborative processes to design system improvements in partnership with community provider groups. Provider training activities will be integrated into this collaborative process of continuous quality improvement as a way to improve system performance.

a.3) Stakeholder Involvement

GREABHA's organizational structure is designed to maximize input from key stakeholder groups through direct consultation, including behavioral health recipients, community stakeholders such as advocacy groups and government agencies, and network providers. The structure ensures stakeholder involvement through the following activities:

- Arizona behavioral health recipients participate in a Consumer Advisory Council, which reviews quality improvement activities, clinical initiatives, and provider training activities, and that provides reports directly to the Chief Executive Officer.
- Arizona community stakeholders participate in Community Advisory Councils that similarly offer guidance related to QI activities and meets directly with the Chief Executive Officer. Community Advisory Councils are intended to involve outside leaders, including businesses and the faith community.
- Community stakeholder involvement is also sought through the Intergovernmental Relations, which provides liaison staff who participate in meetings and committees of key stakeholder groups, such as Child Welfare, AHCCCS, criminal justice agencies, the educational system, police and other first responders, and the Arizona State Hospital.
- Network providers are invited to participate in CBH's clinical advisory bodies, the practitioner advisory Clinical Subcommittee and Credentialing Committee. Consumer groups participate directly on the QMC.



QM Advisory Councils

Community and Consumer Advisory Councils will meet at least quarterly (monthly during implementation) with the CEO in a forum that will encourage open and honest feedback, ideas and constructive criticism of our program. Solutions for improvement will be discussed; action plans will be documented; and dates set for changes as appropriate. These councils will be

structured to hear comments from all interested parties, with meeting notices and reminders posted on the website, sent with claims payments for providers, and posted in providers' offices for consumers. Notices and information on joining these councils also will be published in Consumer and Provider Newsletters. GREABHA will make every effort to encourage participation in these face-to-face information sharing opportunities that take recommendations straight to the top of the leadership structure. The Consumer Advisory Council will consist of consumers and family members (with other stakeholders also invited to participate), and the Community Advisory Councils will consist of 50% consumers, community leaders, and first responders. These Advisory Councils will be formed and scheduled separately under the oversight of the Chief Officer of Consumer and Cultural Affairs, and the Councils will meet directly with the CEO.

Obtaining Direct Feedback from Consumers and Providers

GREABHA also obtains direct feedback from consumers and providers by reviewing their comments received via the following formal measures:

Feedback Method	Frequency	Description
Complaints and Inquiries	Monthly	Data are collected continuously about informal complaints handled by customer service representatives or care facilitators, and formal complaints are logged and investigated by the QM department. Data on informal and formal complaints are examined monthly for trends by the QMC.
Consumer and Family Satisfaction Surveys	Ongoing	Surveys include measures of consumer and family member satisfaction with access to care, appointment availability, services received, outcomes of treatment, the UM process, consumer outreach, and other functions performed by GREABHA.
Provider Satisfaction Surveys	Quarterly	Surveys include measures of provider satisfaction with training activities offered, the UM process, GREABHA's support of clinical best practices, consumer outreach activities, and other functions performed by GREABHA.
Client and Other Stakeholder Satisfaction Surveys	Quarterly	Surveys are sent to staff of governmental agencies that interact with GREABHA, such as the Department of Juvenile Justice, Child Protective Services, AHCCCS, and other entities that interact with GREABHA's Intergovernmental Relations department, assessing satisfaction with GREABHA's efforts to coordinate care for consumers who are served by multiple systems.
Grievances and Appeals	Monthly	Data on grievances and appeals are logged by the Grievance and Appeals staff in the QM Department, and are examined monthly for trends by the QMC.

Any feedback received through these multiple channels will be reviewed by the QMC as a basis for potential action plans, new measurement activities, or formal quality improvement activities, as well as presented to the Consumer Advisory Board for review and suggestions.

a.4) Accreditation and Contract Fulfillment

CBH is currently seeking URAC Health Plan accreditation, which includes an external audit and quality review of CBH's Credentialing, Network Management, Quality Improvement, Utilization Management, and Customer Service departments, as well as HR, IT, and Marketing functions that work with all departments. CBH is committed to quality and to benchmarking performance against external standards, and CBH's policies and procedures are designed to be compliant with both URAC and NCQA accreditation standards. However, CBH recognizes that the terms of GREABHA's contract with ADHS/DBHS may differ from nationwide accreditation standards because of the innovative clinical model proposed in Arizona to support the Arizona principles for behavioral health care. In all cases where the Arizona clinical model and nationwide accreditation standards are not aligned, GREABHA's Arizona operations will be designed to support the Arizona principles and to meet State of Arizona contract requirements. GREABHA anticipates the following potential discrepancies between contractual requirements and nationwide accreditation standards, and proposes the following solutions to address them.

- Credentialing Requirements—URAC and NCQA provide nationally accepted standards for credentialing behavioral health professionals. To meet URAC and NCQA standards, GREABHA must follow a consistent and auditable process for verifying behavioral health professionals' credentials and for updating their network participation status in a timely way. This process does not require that providers be accredited in order to participate in the network, either individually or as a group. CBH uses an NCQA- and URAC-Accredited Credentials Verification Organization (CVO) to expeditiously complete primary source verification requirements that are required by national credentialing standards as part of CBH's commitment to a high-quality provider network. The CVO's average turn-around time for this element of the credentialing process is less than 60 days, and CBH's overall credentialing process makes network status decisions about 80% of providers within 90 days and about 100% of providers within 120 days. CBH monitors and audits all aspects of the credentialing process, and will provide reports to ADHS/DBHS regarding the speed and accuracy of credentialing decisions. GREABHA understands that having a full provider network is essential for ensuring consumers choice and access to care, especially in rural areas where few providers may be available. GREABHA strives to meet consumers' needs by rapidly credentialing behavioral health professionals, while at the same time maintaining a high standard of quality for the behavioral health services offered by GREABHA's provider network, by adhering to nationally accepted standards for conducting provider credentialing activities.

- Paraprofessional Providers of Care—Consistent with the Arizona principles, GREABHA will strive to have at least 50% of behavioral health services delivered by consumers, family members, or paraprofessionals. NCQA and URAC credentialing standards apply only to the credentialing of licensed behavioral health professionals. Therefore, these standards will not apply to the credentialing of paraprofessional behavioral health care providers, and such providers will not be credentialed through CBH's Credentialing Department. Instead, the credentialing of paraprofessional behavioral health care providers will be managed through GREABHA Training Department, which will track the experience and training of all paraprofessional providers. The Training Department will ensure that paraprofessional providers are appropriately screened and initially trained prior to being assigned to work with a behavioral health consumer, and that paraprofessional providers receive appropriate ongoing training and supervision. GREABHA's Training Department will track all training requirements, design new trainings to meet assessed training needs, and monitor paraprofessional providers' completion of ongoing training requirements.

GREABHA will comply with applicable URAC standards if they are consistent with the Arizona principles

The training department will also be responsible for conducting required background checks with non-licensed providers, such as state required background checks for a history of child abuse. CBH currently performs such background checks with its school-based employees in Arizona, and has experience with this type of process.

- Utilization Management—In areas of GREABHA's operations where Utilization Management decisions are made (i.e., inpatient and other higher levels of care), GREABHA will conduct these operations in accordance with NCQA and URAC standards. However, GREABHA will not perform Utilization Management oversight of outpatient and other lower levels of care. Therefore, URAC and NCQA standards related to Utilization Management will not apply to GREABHA's oversight of these levels of care, with the exception of "monitoring" standards such as NCQA's UM 14 (monitoring under- and over-utilization). In the event that under- or over-utilization is identified in a level of care where GREABHA does not conduct UM oversight, GREABHA will still attempt to address the situation and to resolve the over- or under-utilization of that level of care. GREABHA will do this through Network Management and Provider Education activities, rather than through UM oversight or non-authorization of care. For higher levels of care, GREABHA will use well-supported clinical decision making criteria, including the ASAM criteria for making level-of-care decisions in cases of substance abuse.

- Clinical Practice Guidelines—NCQA standards require that MBHOs approve and disseminate Clinical Practice Guidelines that prescribe best practices and standards of care. Because GREABHA believes there are inconsistencies between a prescriptive model of care based on practice guidelines (i.e., "evidence-based best practices") and the Arizona principles of individualized care for all consumers, GREABHA will develop and promote a different type of evidence-based practice, one in which guidelines recommend initial evaluation and tailoring of treatment to meet the consumer's needs, periodic assessment of treatment outcomes in terms of improved functioning from the consumer's perspective, and mid-course adjustment of the treatment plan and goals in order to help consumers achieve desired results. This system will not be prescriptive or based on DSM diagnoses. However, GREABHA will disseminate practice guidelines that educate providers about the Arizona principles and about GREABHA's "clinical pathways" model for promoting evidence-based care. Although the content of the practice guidelines will differ from those traditionally disseminated by MBHOs, GREABHA will comply with NCQA standards in its process for developing, distributing, and evaluating practitioners' adherence to these guidelines and to the requirements of the Arizona principles.

GREABHA will seek to be accredited in all aspects of its Arizona operations that are consistent with nationwide accrediting bodies' standards. Because CBH is currently seeking Health Plan accreditation from URAC, which has a modular structure for accreditation, GREABHA will seek additional accreditation for functions that are not included under URAC's Health Plan accreditation but which are available as separate accreditation modules. For instance, GREABHA may seek URAC Case Management accreditation, or may support the NurseWise support service in doing so.

a.5) Communication of Quality Management Information

Communication between ADHS/DBHS and GREABHA

GREABHA will work with ADHS/DBHS in a quality management planning and improvement cycle that involves an annual QM/UM workplan, periodic reports, ongoing collaboration, and a formal QM/UM evaluation at the end of each calendar year. GREABHA's quality improvement program and workplan will be highly integrated with ADHS/DBHS's QM/UM program and workplan. Behavioral health performance measures will be defined and annual targets, goals, and/or benchmarks set in an annual GREABHA QM/UM workplan. GREABHA's QMC will incorporate measures, goals, benchmarks, and other information from the ADHS/DBHS QM/UM Plan, the AHCCCS Medical Policy Manual, and the ADHS/DBHS Provider Manual. ADHS/DBHS will be invited to participate in the annual planning process, and to suggest any recommended changes to the proposed measures, goals, or benchmarks. Where applicable, the GREABHA workplan will also include industry best practices as a way to evaluate the success of the workplan compared to external standards. Data will be reported on all performance measures specified by the workplan, including clinical and service measures, with most measures reported monthly and some reported quarterly or annually, as specified by the workplan. GREABHA will also monitor specific actions related to each measure that is a focus of performance improvement efforts, and data will be trended over time to determine the effectiveness of these interventions. Finally, GREABHA will provide ADHS/DBHS with a QM/UM evaluation at the end of each calendar year, reporting on the overall results for each measurable quality improvement indicator for each service area, any trends identified, any actions taken, goal achievement, and plans and priorities for the following year.

Reporting from GREABHA to ADHS/DBHS

GREABHA will report standard measures each month to ADHS/DBHS, including all certification/recertification requirements for inpatient Behavioral Health and items on the following list of reports, plus additional reports on the quality monitoring indicators described in Volume 4, Section A.6, Using Information to Identify Improvement Areas. GREABHA's routine reports to ADHS/DBHS will include the following:

Quality Indicator	Frequency	Minimum	Goal	Benchmark
Access to care: Appointment availability for emergency appointments	Monthly	85%	90%	95%
Access to care: Appointment availability for urgent appointments	Monthly	85%	90%	95%
Access to care: Appointment availability for routine assessments	Monthly	85%	90%	95%
Access to care: Appointment availability for routine appointments (medication and other)	Monthly	85%	90%	95%
Sufficiency/comprehensiveness of assessments	Quarterly	85%	90%	95%
Coordination of care with AHCCCS health plans/PCPs	Quarterly	75%	80%	90%
Consumer and family involvement in treatment	Quarterly	85%	90%	95%
Cultural competency of treatment services	Quarterly	70%	80%	95%
Appropriateness of services based on treatment plan	Quarterly	85%	90%	95%

Quality Indicator	Frequency	Minimum	Goal	Benchmark
Informed consent for psychotropic medications	Quarterly	80%	90%	95%
Quality clinical outcomes	Quarterly	80%	82%	85%

GREABHA recognizes that ADHS/DBHS will conduct an Independent Case Review (ICR) annually to assess clinical care measures listed above. The quarterly clinical indicator reports are not intended to replace this ICR, but to provide ADHS/DBHS and GREABHA with supplemental and ongoing data, so that problems can be identified and corrected in a timely way even between annual ICR evaluations. ICR evaluations will provide independent verification of the ongoing process results, and provide additional data for the ongoing quality improvement process.

Each month GREABHA will also provide ADHS/DBHS with data regarding which measures are the focus of a current action plan, and the current target, goal, or benchmark to be achieved. Periodically GREABHA will provide ADHS/DBHS with more formal reports about individual QI activities in progress or completed; GREABHA can provide these formal quality improvement project reports using the NCQA Quality Improvement Activities (QIA) format, the URAC Quality Improvement Project (QIP) format, or another format as specified by ADHS/DBHS.

Annually, GREABHA will provide ADHS/DBHS with a Network Inventory, to quantify the number of providers available in the network by all categories of covered services. In addition to the annual Network Inventory, GREABHA will provide monthly data on network adequacy, including number of providers per 1000 consumers, number of prescribing providers per 1000 consumers, number of peer support providers per 1000 consumers, number of child/adolescent providers per 1000 consumers, and number of Spanish-speaking providers per 1000 consumers. This routine monthly reporting, while less comprehensive in scope than the annual Network Inventory, will allow GREABHA and ADHS/DBHS to conduct more regular monitoring of GREABHA's network adequacy to meet the needs of behavioral health consumers, and will assist GREABHA to initiate any necessary network development activities in a timely manner.

Reporting from GREABHA to Consumers, Providers, and Other Stakeholders

The results of all these metrics, and the action plans to improve when necessary, will be shared with stakeholders on a regular basis. Some of the regular methods of communication are:

- Consumer and Provider Newsletters
- Posting to the website of our latest reports
- Sharing of reports at all scheduled Consumer and Community Advisory Council meetings
- Availability at Community Outreach meetings
- Availability upon request, whenever a consumer or provider calls the GREABHA Consumer and Provider Services department and requests specific information

a.6) Using Information to Identify Improvement Areas

GREABHA's quality management program includes routine monitoring and evaluation of the following major areas. CBH already has experience monitoring these quality improvement indicators in other states, as well as designing action plans and measuring improvements when a quality improvement opportunity is identified. Specific measures, performance targets, and (when necessary) actions for improvement are implemented in each of these areas by each of CBH's business units. These specific measures, targets, and actions will be documented in an individual QI Work Plan, UM Work Plan and Annual Program Evaluation. QI Work Plans and UM Work Plans are updated, reviewed, and approved at least annually.

Based on the ADHS/DBHS annual QM/UM Workplan, ADHS/DBHS Provider Manual, and AHCCCS Medical Policy Manual, and to meet the intent of the Arizona principles, the following information sources will be used:

- **Clinical Services Provided:** GREABHA will monitor the number and type of services provided to behavioral health consumers, including treatment services, rehabilitation services, medical services, community-based services, Family Support Partners, faith community services such as traditional healing, and other services including case management, crisis intervention, inpatient, residential services, and behavioral health day programs. GREABHA will monitor clinical service and quality indicators using encounter data as well as monthly file reviews conducted with each provider group, and supply feedback to providers.
- **Consumer Demographic and Cultural Characteristics:** Each GSA will assess the demographic characteristics, clinical and cultural needs, and risk characteristics of GREABHA enrollees, with drill-down analyses, so that appropriate quality improvement interventions can be designed to meet the unique behavioral health needs of GREABHA enrollees. Demographic and cultural data will be collected from ADHS/DBHS datasets, which may provide enhanced information as ADHS/DBHS improves its data collection in the area of consumers' cultural needs; from contacts with consumers; outreach activities in the community; census data and other public data sources; call center data regarding consumers' linguistic preferences; and based on input from local Consumer Advisory and Community Advisory Councils. GREABHA's analysis of linguistic preferences and needs will include the number of consumers who require TDD telephone assistance or request services in American Sign Language.
- **Availability of Services:** GREABHA will ensure that practitioners are available (a) in sufficient numbers, (b) with adequate coverage of different clinical specialties, and (c) in appropriate geographic locations to serve GREABHA behavioral health recipients. Separate analyses will be performed for each class of services, including treatment, rehabilitation, medical, Family Support Partner community-based faith community services such as traditional healing, and other services including case management, crisis intervention, inpatient residential, and behavioral health day programs. Network sufficiency data will be collected from network development and provider relations data sources, as part of the routine activities of GREABHA's Provider Relations and Provider Training staff. Geographic analysis will use the GeoAccess software and tracking of transportation service requests to consider distance and travel time involved in consumers' ability to access services.
- **Accessibility of Services:** GREABHA will ensure that behavioral health recipients have appropriate levels of access to practitioners, and will also ensure a high level of quality customer service to enrollees by GREABHA employees. This includes (a) access to practitioners in a timely way, and (b) telephone access to GREABHA for customer service. Information about appointment standards is reported at least annually to the QMC. Providers will specifically be assessed for immediate (emergency) appointment availability within 2 hours (or as quickly as possible if access within 2 hours is geographically impractical), urgent appointment availability within 24 hours, routine appointment availability within 7 days, initial appointments for psychotropic medications within 30 days, providers will also be assessed for

compliance with ADHS/DBHS standards for waiting times less than 45 minutes, and GREABHA will assess its transportation service's compliance with standards related to non-emergency transportation (arrival within 1 hour of the scheduled appointment, and departure within 1 hour after the scheduled appointment). GREABHA will also track providers' adherence to referral and intake processes, assessment and service planning processes, outreach, engagement, re-engagement, and closure processes as described in the ADHS/DBHS Provider Manual. Practitioner access data will be collected by GREABHA auditors/trainers monthly.

- **Adherence to Best Practices:** GREABHA will adopt appropriate standards of practice for high-quality clinical care, and GREABHA will evaluate all practitioners' adherence to these standards. As described in Volume 3 of this proposal, GREABHA's Clinical Practice Guidelines follow a "clinical pathways" approach to promoting best practices, and evaluate providers' adherence to a process for developing individualized treatment plans in collaboration with each behavioral health recipient and his/her treatment team, providing services according to the treatment plan, and re-evaluating the plan at specific points in the course of treatment, especially when there is an interruption in the process of care, a change in level of care, or a failure of the treatment plan to achieve the consumer's desired outcomes and goals. GREABHA's monthly file reviews and analysis of clinical practice guideline adherence will also focus on indicators such as sufficiency of assessments, consumer and family involvement in treatment, cultural competency of treatment, appropriateness of services based on the treatment plan, and informed consent for psychotropic medications.
- **Continuity & Coordination of Care:** GREABHA will evaluate and promote continuity and coordination of care between behavioral health and medical practitioners, and also among practitioners at different levels of care within the behavioral health system. We will track the release of information from behavioral health practitioners to behavioral health recipients' PCPs and/or AHCCCS case managers. GREABHA will also track coordination of care indicators that relate to transitions in level or type of care within the behavioral health system.
- **Patient Safety:** GREABHA will monitor any events in clinical care that may indicate a potential safety issue for GREABHA consumers. Patient safety activities will include (a) monitoring of any adverse events experienced by a consumer while under GREABHA's care, including suicide attempts while in a treatment facility, use of seclusion and restraints, discharges against medical advice, and readmissions to an inpatient facility within 30 or 90 days, based on consumer or staff reports; and (b) monitoring of any consumer complaints that suggest a quality of care issue.
- **Complaints and Inquiries:** GREABHA will evaluate complaints and inquiries received (from consumers and from network providers), to identify any potential quality concerns in either clinical care or service delivery. This analysis will include tracking and responding to all formal complaints, grievances, or appeals received by GREABHA, as well as tracking and responding to informal requests or inquiries from consumers providers, or from state agency personnel.
- **Consumer/Practitioner/Client Satisfaction:** GREABHA will conduct a behavioral health recipient and provider Satisfaction Surveys at least annually, and additional satisfaction surveys for other stakeholders in behavioral health care, to assess satisfaction with the quality of service provided by GREABHA. Satisfaction Surveys will cover areas such as behavioral health consumers' satisfaction with GREABHA's telephonic services, consumer outreach, and utilization management activities for higher levels of care, consumers' satisfaction with their individual service plans, provider services, training, and network communication activities, providers' satisfaction with GREABHA administrative policies, preauthorization procedures for higher levels of care, payments, procedures. Stakeholders to participate in this survey will include representatives of other governmental agencies with whom GREABHA staff interact on a routine basis, All results are reported to the QMC.
- **Crisis/Triage Services:** GREABHA will monitor the emergency crisis or triage services provided to behavioral health consumers, in order to ensure availability of crisis services, clinical appropriateness of the care recommendations given, and effectiveness of the crisis/triage services provided.

a.7) Timeliness and Completeness of Data

GREABHA will leverage the expertise and IS system capabilities of Centene's Management Information Systems (MIS) department to help ADHS/DBHS develop a statewide data tracking system that addresses community, state, and human service provider goals and gathers data to assess program quality, impact, cost effectiveness and benefits.

GREABHA will use a proven system for integrating data from diverse data sources into a single information system, thus enabling data to be rapidly analyzed and reported to management

CBH ensures timely and complete reporting of individualized data sets for each CBH client. CBH currently provides managed Medicaid behavioral health services for four states (Indiana, Ohio, Texas, and Wisconsin), and provides reports on all aspects of CBH's operations to the health plans in each state with whom CBH is a subcontractor. In some cases, CBH reports directly to agencies that are responsible for Medicaid program oversight. CBH has the ability to produce client- or state-specific workplans, annual program evaluations, and monthly or quarterly data reports. For example, CBH currently integrates data from diverse data sources, including credentialing data, claims data, authorizations data for higher levels of care, network management data, quality improvement survey data, clinical care coordination system data, appeals and complaints data, and other data sources. Data obtained from provider site visits include appointment availability, intake, referral, engagement, and re-engagement of consumers, use of best practices and the Arizona principles, evaluation of consumers' functional outcomes, treatment planning and treatment team composition, consumer and family member involvement in the process of care, and availability and use of non-clinical support services. Data extracted from each database or other data source are then linked to related data from other sources (e.g., by consumer, by provider, by episode of care), so that formal analyses can be performed. CBH's parent corporation, Centene Corporation, maintains a Research and Development department that integrates data from various sources to answer applied questions related to the management of care. Monthly quality indicators are extracted to a separate QM database, which stores data in a standardized numerator/denominator form for easy access and comparison across service areas or locations. The database is used to report aggregate quality improvement information as part of CBH's Quality Management process, and can also be used to perform drill-down analyses in the event that a specific quality indicator is flagged as being out of compliance with CBH's standards. Quality tracking tools such as control charts are used to review indicators over time. CBH's current database systems for each aspect of CBH operations (QM, UM, etc.) are described in Volume 5.

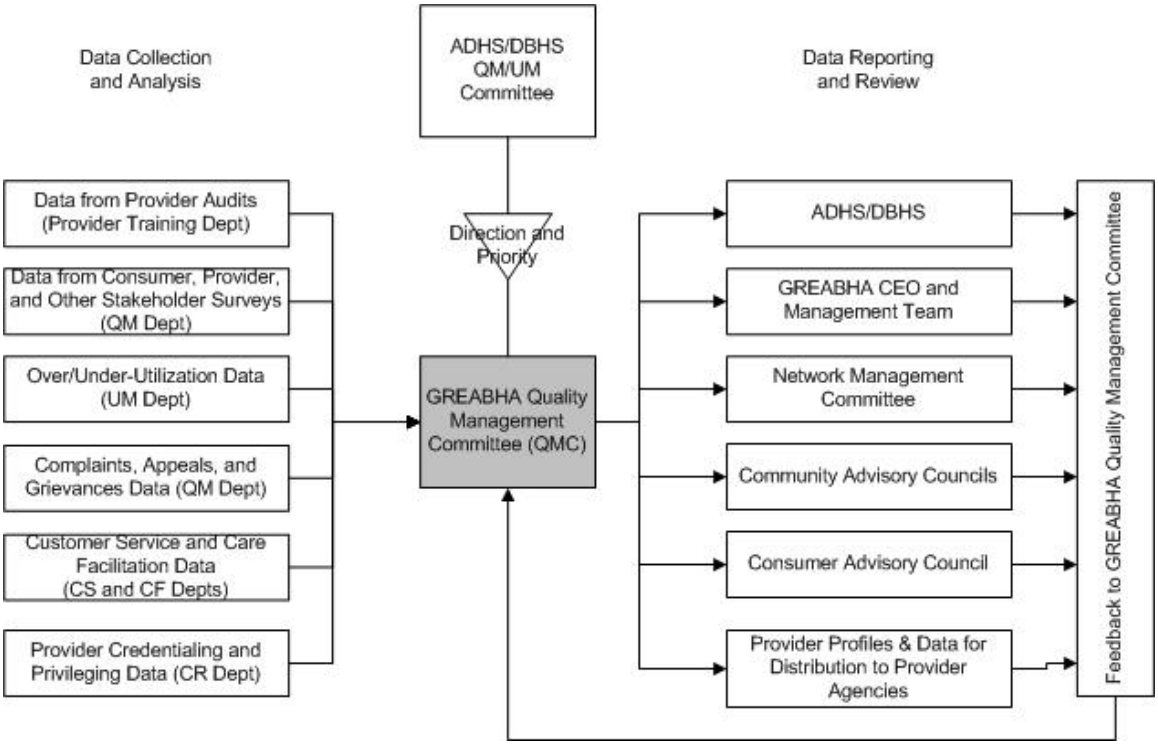
At least annually, CBH's Quality Management and IS Departments conduct a data integrity audit of each database or other tracking system in use. A formal data integrity report is prepared, summarizing the data sources, reliability information about each data source, and any problems discovered. In the event that any problems with data quality are discovered, an action plan is completed to address the problem in a timely manner. CBH also tracks any quality complaints from clients, consumers, or providers related to the accuracy or content of data reports. Any such complaints are investigated within 30 days, the issue is resolved if a problem is found, and the resolution is reported to the person or agency making the complaint.

GREABHA's automated report distribution method will allow rapid and timely dissemination of key data elements to a variety of stakeholders in the behavioral health care system, such as providers, consumers, and ADHS/DBHS

CBH ensures timely data reporting through the use of automated report generation software. Based on contract requirements, report templates are designed to meet each client's custom data submission needs. These templates are created using the Crystal Reports product, an industry-standard report writing software package. Each template is programmed to retrieve information from relevant data fields in specific databases, to manipulate and perform any necessary calculations on that data, and to limit display of

the data based on specified report parameters (e.g., service area, month). These templates are then stored on a network location, where they interface with a server-side product from the same manufacturer, Crystal Enterprise. The Enterprise product allows automation and automatic distribution of the pre-programmed report templates. For instance, a report can be programmed to run automatically on a weekly or monthly basis, and then to automatically save the output, e-mail it to a list of recipients, or store it on a website location that can be accessed by anyone with the appropriate access log-on from anywhere in the world. CBH is developing "dashboard" reports that would give real-time indicators regarding program performance based on various quality monitoring activities.

The following chart shows the flow of information through the QMC, including collection and communication of data, analysis, input from stakeholders, and reporting to stakeholders at all levels of the behavioral health service delivery system:



a.8) Process and Focus of Provider Monitoring and Performance Improvement Activities

Provider Monitoring and Performance Improvement Measures

Rationale for selection of performance measurement categories in the context of key profiling concepts is described below. As the provider profiling method for Arizona continues to evolve, GREABHA will seek input from provider focus groups and community stakeholders as part of the ongoing process of developing appropriate measures, targets, and benchmarks for profiling activities.

Performance Measure	Key Concepts for Selecting Measure	Rationale for Selection
Appointment Availability/ After Hours Access	• Compliance with the Principles of the Arizona principles • Meaningfulness to the provider and populations served • Ability of provider to impact performance	Consumers have identified appointment access measures as critical to treatment success and continuity of care. Provider assessment of this data may impact office operating procedures including office staffing patterns and hours of operation.
Clinical Best Practices	• Compliance with the Principles of the Arizona principles • Meaningfulness to the provider • The ability of the provider to impact performance • Meaningfulness to the populations served	The use of best practices, including practices for tailoring treatments to the needs, goals, and cultural context of the consumer, is essential in providing effective treatment and helping consumers to achieve their goals. Providers practicing outside community norms or recommended practice patterns may offer less than optimal care
Service Delivery Model	• Compliance with the Principles of the Arizona principles • The ability of the provider to impact performance • Meaningfulness to the populations served	The Arizona principles involves a set of high-quality technical interventions, we well as an approach to care that is welcoming, that continually engages and re-engages consumers and their family members, that promotes optimism and hope about the prospect of recovery and consumers' ability to achieve meaningful goals, and that provides continuity of care.
Utilization Management	• Meaningfulness to the provider • The ability of the provider to impact performance • Meaningfulness to the populations served	Utilization measures assist the entity profiled to compare their level of utilization with like providers in the community. This performance measure assists in identification of outliers who may be practicing in a manner inconsistent with community norms or recommended practice patterns..
Consumer complaints and appeals	• Meaningfulness to the provider • The ability of the provider to impact performance • The ability of the plan to provide measurable and reliable data at the provider level.	Consumer complaint data enables the entity profiled to assess perception of services provided to their customers and to evaluate the level of customer satisfaction compared to similar entities. This data complements satisfaction surveys and consumer complaint data performed by the entity directly offering a more complete picture of areas to be identified for performance improvement.

Process for Provider Monitoring and Performance Improvement

GREABHA distributes profiles on an annual basis. To better serve contracted agencies with multiple providers with individually assigned membership, GREABHA offers the option to produce provider profiles at a group level. Individual provider profiles for those providers who are part of a group contract may be delivered to an entity identified by the contract holder or to the individual profiled by mutual agreement between the plan and the group contract holder.

Following production and prior to profile distribution, GREABHA's Quality Management Committee assesses system-level and high-volume-provider level performance across all performance measures. As part of this system level review, both best practices and plan wide areas for performance improvement are identified. This review also includes assessment of appropriateness of identified thresholds and performance targets utilized in the completed profiling cycle. Once these tasks have been accomplished, plan representatives are prepared to work most effectively with providers as profiles are distributed.

The second step in the profiling process is distribution. GREABHA's network management staff will provide written and verbal feedback to providers, and will offer them a chance to comment on the data reported prior to finalizing the profile. If a provider's results are far out of compliance with GREABHA standards, or if the provider requests it, GREABHA offers an in-person meeting between the provider, GREABHA network management staff, and the GREABHA CMO if necessary.

Coordination of Performance Improvement Activities

To motivate the provider and facilitate improvement, two key activities occur at the time provider profiles are distributed. The first key activity within this information exchange is to actively listen to the provider's assessment of his/her performance and the provider's reaction to data reported in specific performance measures. The second key activity is to empower the provider to select performance improvement activities, consistent with profiled performance measures, that the provider feels are most relevant to his/her practice. Once identified, mutually agreed upon provider specific goals can be established. The plan and provider roles are identified and reporting needs to track performance through the current profiling cycle are identified.

Performance Improvement Activities are designed in collaboration with providers. GREABHA will help providers to utilize our continuous quality improvement process and to monitor and improve their own practices

Following identification of and commitment to provider specific targeted levels of performance, the provider receives written follow-up to re-confirm the performance goals established for the current year and to reiterate and re-enforce methods discussed to impact improvement. An interim reporting cycle is established in conjunction with the provider to assure timely feedback as well as providing the status toward meeting established performance goals.

As part of the ongoing process of developing and refining provider profiles, GREABHA will conduct provider focus groups, will review provider profile elements with the Consumer Council and Community Councils, and will solicit feedback from CBH's national practitioner advisory group, the Clinical Subcommittee. GREABHA will refine provider profile measures over time to develop indicators that are relevant to the Arizona principles, that are meaningful to consumers and providers, and that result in meaningful quality improvements. GREABHA will offer providers individualized support and technical assistance, and will work with individual providers on an ongoing basis to improve their scores on profiled measures over time.

a.9) Utilization Management Function and Structure

GREABHA's utilization management process incorporates industry best practices and Medicaid-specific modifications that have been adapted and revised over time to reflect the specific needs of the Medicaid population. Behavioral health recipients will be free to self-refer for any type of outpatient behavioral health care; GREABHA will require preauthorization only for Level 1 Services (e.g., residential treatment), as described in Volume 3, Section N. All utilization management functions will be performed by GREABHA staff members, who will be licensed behavioral health professionals operating under the supervision of the GREABHA Chief Medical Officer. GREABHA will not subcontract utilization management to contracted provider groups.

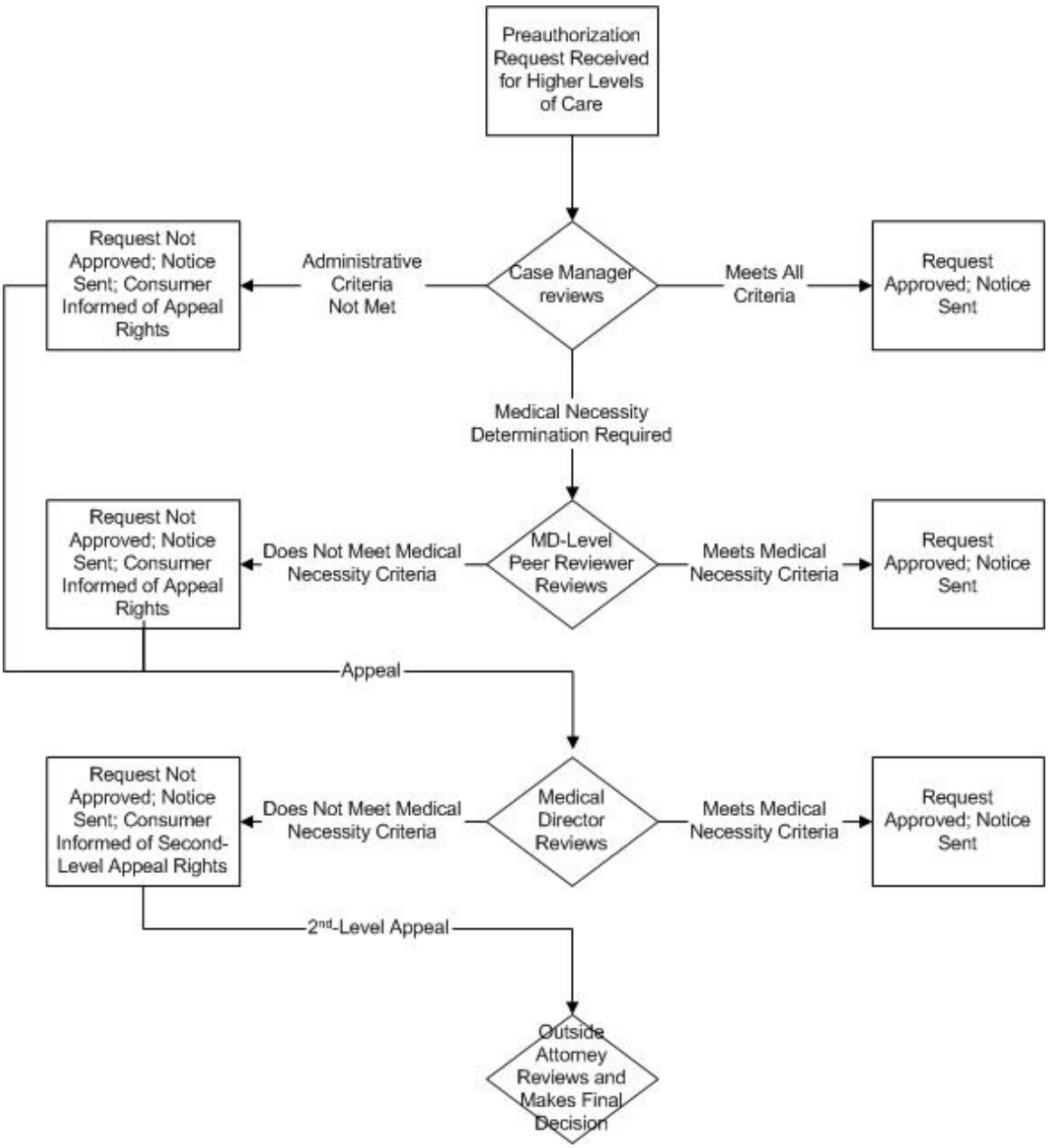
GREABHA's Utilization Management Department will be staffed by Master's-level behavioral health professionals (LMSW, LMFT, RN, etc.) with a minimum of three years clinical experience. Based on GREABHA's experience in other states that require preauthorization only for higher levels of care, staffing for the UM department will be as detailed in the following table. These staff members will follow GREABHA's guidelines to make authorization decisions for higher levels of care for different age groups and populations, including adults, children/adolescents, geriatric patients, and patients with substance abuse disorders. GREABHA Utilization Management staff will send ADHS/DBHS-required notices and letters, using an automated system that generates customized letters that place the consumer's information in the required formats with "push-button" functionality. This feature prevents user error, and ensures that all required notices will be sent to the correct individuals within the ADHS/DBHS-required timeframes.

Position Title	Job Description	Reports To	GSA 1 - Number of FTEs	GSA 2 - Number of FTEs	GSA 4 - Number of FTEs
Care Manager	Clinical staff member who performs initial review of authorization requests for higher levels of care, and issues authorizations when the request meets administrative and medical necessity criteria	UM Review Administrator	1	0.5	0.5
Peer Reviewer	MD-level UM reviewer under contract to perform utilization review for GREABHA when a preauthorization request does not appear to meet medical necessity criteria; makes determinations about whether a request meets criteria or not, and gives feedback and consultation to requesting providers	Chief Medical Officer	PRN		
UM Director	Clinical staff member who oversees the work of Care Managers and the process of preauthorizing services for higher levels of care	Chief Medical Officer	1		
Chief Medical Officer	Has ultimate responsibility for all clinical aspects of GREABHA operations. Monitors and oversees the UM process.	CEO	1		

GREABHA's procedures for authorizing higher levels of care are compliant with the requirements of 42 CFR: For levels of care where preauthorization is necessary, ADHS/DBHS's utilization

management guidelines will be applied by GREABHA's licensed behavioral health professionals in a consistent and clinically appropriate way, to authorize or retrospectively review services for behavioral health recipients For Level 1 Services, the UM review process is the same for both prospective (i.e., admission) and concurrent (i.e., continued stay) review. Master's level Care Managers who are licensed in a behavioral health specialty perform initial clinical review of any requests for higher levels of care, including inpatient, residential, intensive outpatient, or day treatment/partial hospitalization. These clinical personnel review each request against ADHS/DBHS's UM guidelines, authorize care if it meets medical necessity criteria, and refer it for peer review if it does not appear to meet the criteria. If the care is determined to have been medically necessary, the Care Manager issues an authorization and sends an approval letter to the requesting provider, including a tracking number. Any authorization, whether initial or concurrent, is issued for a specified number of days, after which the case must be reviewed again and another authorization obtained if continuing care is needed. The Master's-level clinician never issues a denial; when a case does not appear to meet medical necessity criteria, it is reviewed by a clinical Peer Reviewer, who is a specialty-matched, Board certified MD/DO-level behavioral health practitioner with at least five years clinical experience. This Peer Reviewer makes a decision about whether the care is medically necessary, and consults with the requesting provider to inform him/her of the decision. If the provider disagrees with the reviewer and so requests, he/she is entitled to an appeal with a new reviewer who has not had any previous involvement with the case to render another determination of medical necessity. At the time of any denial of care, the Care Manager issues a letter that explains the decision and informs the consumer and requesting provider about GREABHA's appeals process as well as the availability of an outside attorney for second-level appeals in the event that a consumer is not satisfied with the results of GREABHA's first-level appeals process. The Peer Reviewer is available by phone for consultation with the provider upon request.

GREABHA's process is summarized in the following flowchart:



Retrospective (post-service) review is conducted in situations where GREABHA is informed about behavioral health treatment only after the service has already been delivered (e.g., when a behavioral health recipient presented directly to an emergency department for behavioral health services and was admitted to inpatient care based on the judgment of the treating professional that hospitalization was medically necessary). For retrospective review, a Master's-level Care Manager who is licensed in a behavioral health specialty first reviews the request to determine whether exceptional circumstances existed (e.g., inaccurate benefit information was communicated to the Provider, an emergency situation prevented the Provider from obtaining a preauthorization during regular business hours, etc.). If exceptional circumstances do not exist, an administrative denial is issued. If there is evidence of exceptional circumstances, the Care Manager then reviews the services provided against ADHS/DBHS's UM Guidelines to verify that the services were medically necessary. If the care is determined to have been medically necessary, the Care Manager issues an authorization and sends an approval letter to the Provider, including a tracking number. If exceptional circumstances existed but the case does not appear to meet medical necessity criteria, the Care Manager forwards the case to a clinical Peer Reviewer (MD/DO-level practitioner) for a final determination. If the Peer Reviewer determines

that the care was not medically necessary, the Care Manager issues a letter that explains the decision and informs the behavioral health recipient about GREABHA's Appeals process as well as ADHS/DBHS's second-level external appeal process, and the Peer Reviewer is available by phone for consultation with the ordering provider upon request.

GREABHA values our collaborative working relationship with behavioral health facilities that provide inpatient care, and our behavioral health Care Managers actively follow patients who are receiving inpatient care to ensure that each behavioral health recipient receives the necessary services, as well as to assist with discharge planning. Based on this collaborative process, the need for retrospective review is generally minimal. However, when retrospective review is necessary, it is always conducted in a fair, non-punitive manner, based solely on the information available to the provider at the time of the decision to provide care. Retrospective review would never be conducted in cases where GREABHA has already issued authorizations for the services delivered. If a facility requests an authorization for care after a behavioral health recipient has been admitted but before discharge, the initial authorization begins on the date of notification; for any care delivered before that date, the facility could request a retrospective review. If the facility requests an authorization after the consumer has been discharged, the entire admission would be retrospectively reviewed. In cases where an authorization was issued for a certain number of days and the facility provided additional days of care without obtaining another authorization, the extra days would be administratively denied, and the facility could request a retrospective review for that part of the treatment episode. This situation rarely occurs, however, because GREABHA's Care Managers proactively call facilities to assist with discharge planning at the time that an authorization expires.

a.10) Utilization Monitoring

The effective implementation of the Arizona principles requires careful monitoring of under- and overutilization of all services delivered within the system. In addition to serving as indicators of high quality clinical care, monitoring of utilization by service type is important. GREABHA will ensure that the service delivery system supports Arizona's significant shift from traditional behavioral health services delivered by professionals toward community based and support services, including services delivered in part by consumers and their family members. GREABHA will use behavioral health encounter data to analyze behavioral health services use based on population (Title XIX vs. Non-Title XIX SMI vs. other Non-Title XIX, etc.), type of service (e.g., treatment services vs. support services vs. inpatient services, etc.), and service site (e.g., outpatient clinic vs. Level I hospital vs. Level I subacute facility, etc.). Thresholds are used to detect incidences of under- and over-utilization. When under- or over-utilization is identified, further quantitative analysis is conducted to determine whether the variation can be explained and is expected based on current circumstances. If the variation cannot be explained or is unexpected, then a root cause analysis is performed to identify the factors driving the variation. Once the factors driving the variation are identified, actions are implemented to improve performance, and follow-up monitoring schedules are established. Participating practitioners are involved in the analysis, and when applicable, action plans are implemented to improve their performance. Results of under- and over-utilization monitoring activity will be reported to the Arizona QMC at least quarterly.

GREABHA will rely on the following data sources and monitoring indicators to detect potential instances of under- or over-utilization based upon the ADHS/DBHS, Covered Behavioral Health Services Guide:

Data Source	Measures/Indicators	Drill-Down Analysis	Frequency
Encounter Data	• Outpatient Visits per 1000 • Outpatient Average Length of Treatment • O/P Substance Abuse Visits per 1000 • O/P Substance Abuse Average Length of Treatment • Rehab Services per 1000 • Support Services per 1000 including case management • Crisis Intervention per 1000 • Service Mix (Treatment vs. Support Services vs. Medical Services, etc.) • Subacute Days per 1000 • Subacute Admits per 1000 • Subacute Average Length of Stay • Behavioral Health Day Programs per 1000 • Behavioral Health Day Programs Penetration Rate Days Per 1000 • Behavioral Health Day Programs Average Length of Treatment	• By GSA • By Provider Agency • By Individual Practitioner	Monthly
Pharmacy Data	• Polypharmacy (more than 2 drugs in same category/more than 3 drugs overall) • Medication Adherence Rates • Potential Abuse of Prescription Drugs (multiple pharmacies, multiple	• By GSA • By Provider Agency • By Individual Practitioner	Monthly

Data Source	Measures/Indicators	Drill-Down Analysis	Frequency
	MDs, etc.)		
Data for Higher Levels of Care	• Residential Days per 1000 • Residential Admits per 1000 • Inpatient Days per 1000 • Inpatient Admits per 1000 • Inpatient Average Length of Stay • Detox Days per 1000 • Detox Admits per 1000 • Detox Average Length of Stay	• By GSA • By Provider Agency • By Individual Practitioner	Monthly

Over- and under-utilization data will be reviewed in the aggregate on a monthly basis by the QMC, to identify any overall trends observed, including trends in service utilization that suggest noncompliance with the Arizona principles for behavioral health care (e.g., an increase in inpatient treatment with a corresponding decrease in support service use, which would indicate a quality problem). When quality problems are identified, appropriate interventions will be initiated, to include additional provider outreach and training activities, consumer education, care coordination activities with facilities, or other initiatives as are deemed necessary by the QMC.

More detailed over- and under-utilization data, broken down by specific provider agencies, will be examined by the Arizona Network Management Committee. This committee will determine whether specific provider groups require additional education or technical assistance to successfully implement the Arizona principles for behavioral health care. Actions taken by the Network Management Committee can include provider education activities, outreach and coordination with specific providers, and feedback to the Credentialing Committee if a problem is significant and/or longstanding enough that the Network Management Committee believes the provider's network status should be changed to "inactive."

Finally, provider-specific utilization management data will be a key element of GREABHA's provider profiling activities in Arizona. Provider profiles will highlight UM and QM indicators related to a specific network provider's performance over a particular period of time. GREABHA will also use these profiles to provide normative data about the performance of other providers in the network. This type of peer comparison feedback can be a powerful motivator for change among health care providers. Finally, profile information will include benchmark or best practice statistics for each measure, as an aspirational goal. Profile measures and presentation of profile information will be designed to support and enhance network providers' compliance with the Arizona principles for behavioral health services.

b.1) Notice Requirements

GREABHA will use multiple methods to inform behavioral health recipients of their right to appeal any adverse decision made by GREABHA, and all GREABHA staff members will be trained in how to educate behavioral health recipients about their appeal rights and how to assist behavioral health recipient's consumers, family members, or personal representatives in filing an appeal.

Basic methods to inform behavioral health recipients of their appeal rights are as follows:

- Information about the appeals process will be included in the GREABHA Member Handbook, including tear-out appeal forms in both English and Spanish that can be used to document issues and send them directly to GREABHA. The handbook will outline the timeframes for notices and delivery by certified mail, as well as the processes for requesting information in alternative formats and obtaining interpretative services.
- At the time of each behavioral health recipient's engagement in the process of care, telephonic peer-to-peer outreach workers will provide a verbal explanation of the appeal process during the welcome call made to each new consumer at the time he/she enters the system of care.
- GREABHA providers will be required to post the Notice of Client Rights at each practice location.
- At the time a behavioral health recipient goes through the intake process, GREABHA's contracted providers will give information about the appeal process to the behavioral health recipient and his/her family members or other representatives participating in the process of care.
- GREABHA will periodically distribute reminders and updates about the appeal process in Consumer Newsletters sent to all enrollees.
- GREABHA will post information about how to file an appeal, and behavioral health recipients' appeal rights, on our website. This will include a secure on-line form that consumers can use to file an appeal directly.
- Whenever a non-authorization is issued in response to a service request for higher levels of care, GREABHA's Utilization Management staff will use the UM section of GREABHA's clinical database to automatically generate a notification in the ADHS/DBHS-approved format, with the appropriate information populated for the individual behavioral health recipient including information about how to file an appeal.
- If a behavioral health recipient, family member, or personal representative calls GREABHA and wishes to file a verbal appeal, GREABHA staff will be trained to assist them in doing so. If the caller requires services in Spanish, a Spanish-speaking GREABHA employee will assist them. If the caller requires services in another non-English language, translation services are used to assist them. For callers who are hearing impaired, GREABHA will offer TDD services. Initial training on how to facilitate the appeals process will be provided to all GREABHA staff who interact with consumers by phone, and annual re-training is also provided. This includes training in how to work with callers from various cultural groups and how to assist persons with serious and persistent mental illnesses, so that consumers will have the maximum amount of support in becoming aware of and exercising their rights to an appeal.

GREABHA and/or its providers will also supply the Notice at time of a consumer's discharge from any higher level of care. GREABHA and our contracted providers will abide by all ADHS/DBHS policies and timeframes for disseminating notices. At the time any behavioral health recipient is discharged from a higher level of care, one of the following procedures is used to give the behavioral health recipient written notification of his or her appeal rights:

- GREABHA providers will be required to give the behavioral health recipient written notification of his or her appeal rights and to obtain their signature indicating that the appeal rights were received, as part of the discharge planning process for higher levels of care. GREABHA UM Department staff will remind network facility providers of this requirement during the discharge planning process.
- If a signed acknowledgement of receipt of the notification is not received at the time a behavioral health recipient is discharged from care, GREABHA will send the notice directly to the consumer by certified mail. Their signature is obtained upon receipt.
- If the behavioral health recipient address is not accurate or the certified letter is returned, GREABHA's staff will contact the behavioral health recipient's most recent provider to obtain updated address information, and will re-send the certified letter with the notice of appeal rights.
- In cases where a non-certification decision is made, whether or not the behavioral health recipient has yet been discharged from care, the GREABHA Care Manager involved in review of the case will use GREABHA's clinical database to automatically generate and send a non-certification letter to the provider who made the authorization request, and will also a copy of the notice of appeal rights. The non-certification letter instructs the provider to give the notice to the behavioral health recipient, and to obtain their signature to acknowledge receipt. If the behavioral health recipient's acknowledgement is not received, GREABHA will send the notice to the them by certified mail, following the process described above.

Content of Notices

The following information will be included in the notices provided to persons determined to have a serious mental illness or persons applying for SMI services.

- the person's right to appeal and to an administrative hearing
- the method by which an appeal and an administrative hearing may be obtained
- that the person may represent himself/herself or use legal counsel or other appropriate representatives
- the services available to assist the person from the Office of Human Rights, Human Rights Committees, Protection and Advocacy System and other peer and advocacy services
- an explanation of the process for a second-level appeal through ADHS/DBHS's Fair Hearing process if the consumer is not satisfied with the results of the first-level appeal

Quality Monitoring and Improvement

GREABHA's Grievance and Appeals Coordinator will monitor GREABHA's response to all appeals received, including timely response to appeals and timely resolution of appeals. GREABHA's Quality Management Department will oversee the appeals process, and also monitor GREABHA's success in delivering notices of appeals rights to all behavioral health recipients at the time of discharge from a higher level of care and at the time of any non-certification decision. These performance metrics will be reported monthly to the GREABHA Quality Management Committee, data will be trended and compared to benchmark and goal levels to identify opportunities for performance improvement, and quality improvement activities will be initiated as necessary.

b.2) Grievance and Appeals Function

GREABHA's effective implementation of the Arizona principles will minimize consumer grievances and appeals. To meet ADHS/DBHS's requirements when a grievance or appeal does occur, and to promote consumer and practitioner satisfaction with the resolution of appeals, GREABHA will maintain an internal function dedicated to the identification and prompt resolution of oral and written complaints, SMI grievances, member appeals and provider claims disputes. This grievance and appeals function includes processes for:

- Delivering all notices within ADHS/DBHS timeframes and requirements
- Expedited appeals if we receive information from the eligible person or his/her provider and determine that taking the time for a standard resolution could seriously jeopardize the person's life or health, or ability to attain, maintain, or regain maximum function, including when a physician or practitioner with knowledge of the enrollee's medical condition determines the appeal to be urgent.
- Tracking receipt, progress toward resolution and outcomes of grievances and appeals
- Aggregating, analyzing and reporting of grievance and appeals data to appropriate internal and external individuals and committees/subcommittees for review and action as appropriate
- Ensuring that Appeal/grievance decision makers have no previous involvement in the case.

As part of our commitment to provide excellent customer service, all GREABHA staff will be trained in the grievance and appeals process and expected to assist providers and consumers in accessing the appropriate mechanism for filing complaints, appeals and grievances. The following depicts the number of personnel who have primary responsibility manage the grievance and appeals function, their qualifications and roles and responsibilities:

Position	Qualifications	Roles & Responsibilities	FTEs
Quality Management Administrator	5 years experience in behavioral health QM; professional degree in a health care field (RN, MSW, PhD, etc.)	Oversight of QM contract requirements Collaborates with Grievances and Appeals Administrator, Intergovernmental Relations, Utilization Management, Provider Training, and Consumer Outreach to identify and resolve issues related to Complaints, Grievance and Appeals. Assists consumers to submit a second-level appeal to an independent attorney per the appeals process set forth by ADHS/DBHS Works with IS and IT staff to ensure that data are tracked and reported accurately, and designing and implementing new programs to meet ADHS/DBHS QM program goals.	1
External Attorney	Legal background Licensed AZ Attorney or certified AZ Paralegal and External contractor	Oversees and ensures appropriate processing of SMI grievances, member appeals and provider claims disputes Assists consumers to submit requests for Fair Hearings, Judicial Review Provides services for representation of GREABHA or our contracted provider for administrative hearings or judicial reviews. Tracks data about all grievances and appeals and their resolution, and reports this information to the Quality Management Committee for	1

Position	Qualifications	Roles & Responsibilities	FTEs
		monitoring and improvement as necessary. Supervises Complaint Coordinators	
Grievance & Appeals Administrator	5 years healthcare experience	Oversight, administration, and implementation of the Fraud and Abuse program Collaborates with Grievances and QM Administrator, Intergovernmental Relations, Utilization Management, Provider Training, and Consumer Outreach to identify and resolve issues related to Complaints, Grievance and Appeals that indicate suspected or confirmed fraud and abuse. Assists consumers to submit a second-level appeal to an independent attorney per the appeals process set forth by ADHS/DBHS	1
Grievance & Appeals Coordinator	3 years healthcare experience	Day-to-day processing of grievances and appeals Monitors compliance with notice and timeframe requirements per ADHS/DBHS guidelines. Assists consumers to submit a second-level appeal to an independent attorney per the appeals process set forth by ADHS/DBHS Reports complaint, grievance and appeals data, concerns, issues and outliers to the Grievance and Appeals Administrator. QM Administrator and Intergovernmental Relations Officer Maintains a record of each complaint/grievance, any complaint proceedings and any actions taken on a complaint for seven (7) years from the date of the receipt of the complaint. All consumer files are maintained in a secured electronic site or in a locked record file.	1
Chief Medical Officer	MD/DO-Level Behavioral Health Practitioner with 10 years' experience and Board Certification	Has no previous involvement in the case. For appeals of decisions to reduce, deny, or terminate requested health care services based on medical necessity determinations, the Chief Medical Officer reviews all first-level appeals. In cases where the appeal involves a specialty that is not the Chief Medical Officer's expertise, he or she seeks consultation from an appropriately qualified behavioral health practitioner to make a decision.	1

b.3) Grievance and Appeals Process

Complaint Tracking and Resolution Process

GREABHA shares ADHS/DBHS's belief that persons seeking or receiving behavioral health services should always be encouraged to resolve issues at the lowest possible level. However, GREABHA always ensures that persons are aware that a complaint and appeal process is also available when necessary. A compliant is defined as an expression of dissatisfaction from a consumer or behavioral health recipient with regard to any aspect of his/her care, other than the appeal of actions. An action that is subject to appeal through the Title XIX/XXI Member Appeal process is not handled as a complaint but rather as an appeal pursuant to the ADHS/DBHS Policy and Procedure Manual. Routine inquiries are not considered to be complaints.

The following describes our complaint resolution process:

1. Eligible and enrolled persons, their families or legal guardian(s), authorized representatives, other agencies, or the public may file a complaint orally by using GREABHA's toll-free number, or in writing.
2. Upon receipt of a verbal complaint or concern, the staff member receiving the complaint completes a Complaint Form, documenting the concern and any actions taken by the complainant to attempt to resolve the concern. The form is forwarded to the Complaint Coordinator (CC). GREABHA's CC, under the direction of the Grievance and Appeals Administrator (G&AA) will be responsible for ensuring that complaints are processed, tracked and resolved within ADHS/DBHS timeframes and requirements. The CC will be trained to distinguish a complaint from a Title XIX/XXI appeal of an action.
3. Written complaints letters are date stamped when received and forwarded to the CC.
4. When information is received that the individual has a limited English proficiency or other communication need.
    - For individuals needing translation in the prevalent non-English language within the region, GREABHA will provide a written translation of the documents.
    - For individuals needing translation in a language not considered a prevalent non-English language within the GSA or requiring alternative formats (such as TTY/TTD), GREABHA will provide oral interpretation or make alternative communication formats available at no cost, as needed.
5. In the event that GREABHA receives a complaint referred from ADHS/DBHS, the CC will provide an oral or written summary to ADHS/DBHS that describes the resolution of the complaint within the timeframe specified by ADHS/DBHS. The CC ensures that any corrective actions or other action directed by ADHS/DBHS is implemented.
6. The CC enters the complaint in the complaint tracking section of GREABHA's clinical system.
7. The CC may call the complainant to obtain additional information or clarification of the issues as necessary.
8. The CC sends an acknowledgment letter within five (5) working days of complaint receipt. When the complainant is voicing concerns on behalf of an enrollee, GREABHA will send the enrollee an acknowledgment letter and request for authorization to appoint another individual to act on their behalf. The acknowledgment letter includes a description of the complaint/grievance procedures, and resolution timeframes.
9. The CC researches the substance of the complaint.
    - If the complaint does not include any clinical issues, the CC proceeds with the resolution.
    - If the complaint includes potential clinical issues, it is forwarded to a clinical staff member or the Chief Medical Officer for review. Clinical staff making decisions regarding complaints involving clinical issues will not have been involved in any previous level of review or decision-making..

10. The CC issues a response letter to the complainant providing GREABHA's resolution as quickly as the health condition affected requires, but not later than 90 days of receipt, unless an extension is in effect (see #11 below). The letter includes: the resolution, the specific medical and contractual reasons for the resolution, how to request an ADHS/DBHS Administrative Hearing and a description of the internal process for appeal of the determination.
11. The resolution timeframes for complaints will be extended for up to 14 calendar days, if the affected behavioral health recipient requests the extension.
12. ADHS/DBHS is notified of the complaint resolution and/or receives copies of complaint documents according to contractual requirements.
13. Aggregate complaint data is submitted to the Quality Management Committee for trending and analysis. along with metrics to ensure the timeliness of processing is met. These standard metrics are reported monthly and reviewed by the Quality Management Committee as well as GREABHA's Consumer Board.

Administrative Appeal Tracking and Resolution Process

An appeal is defined as a request for review of an action including: denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or part, of payment for service; the failure to provide services in a timely manner; the failure to act within established timeframes for resolving an appeal or complaint and providing notice to affected parties; and for a Title XIX/XXI eligible person in a rural area, the denial of the Title XIX/XXI eligible person's request to obtain services outside the network. For administrative appeals, the following process is used:

1. If an administrative appeal is filed, the CC forwards the full investigation case record to the ADHS/DBHS Deputy Director through the ADHS/DBHS OGA.
2. If OGA rejects the investigator's report for insufficiency of facts, the mater is returned to the GREABHA G&AA with instructions for further action. Further investigation will be conducted and a revised report and decision submitted to the ADHS/DBHS Deputy Director within 10 days.
3. Any grievant or person who is the subject of the grievance who is dissatisfied with the decision of the ADHS/DBHS Deputy Director may request an administrative hearing before an administrative law judge within 30 days of the date of the decision.
4. After the expiration of the time frames for administrative appeal and administrative hearing, or after the exhaustion of all appeals regarding outcome of the investigation, GREABHA or the Deputy Director of the ADHS/DBHS will take any corrective action required and add to the record a written, dated report of the action taken.
5. The CC will maintain records as follows: All documentation received and mailed related to the grievance and investigation process will be date stamped on the day received. A grievance investigation case record for each case will be maintained..
6. The ADHS/DBHS, OGA, GREABHA maintain a public log of all grievances or requests for investigation in the ADHS/DBHS OGA Database. Entry must be made within three working days of each reportable event.

Grievance Tracking and Resolution Process

A Grievance or Request of Investigation is defined as a complaint that is filed by a person with SMI or other concerned person regarding a violation of the person with SMI's rights or a condition requiring investigation. GREABHA's CC will respond to grievances and requests for investigations in accordance with ADHS/DBHS timelines and procedures

Grievances reported to GREABHA will be addressed in the following manner:

1. Persons requesting or receiving services will be notified of their right to file grievances or request investigations according to the requirements in ADHS/DBHS Policy GA 3.5, Notice Requirements.
2. The CC will assign a unique ADHS/DBHS Docket Number for each Grievance or Request for Investigation filed, including: the letter “B” for those issues investigated by the ADHS/DBHS; the RBHA letter code; date of receipt of the Grievance or Request for Investigation; letter code “S” designating that the person is enrolled in services for the Seriously Mentally Ill; and four-digit sequential number.
3. The Director of Quality Management reviews incident reports submitted as required in ADHS/DBHS Policy to determine if a grievance issue or condition requiring investigation exists.
4. Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by GREABHA or one of its subcontracted providers and which does not involve a client death or an allegation of physical or sexual abuse, shall be filed with and investigated by GREABHA.
5. For a pending grievance or request for investigation the GREABHA G&AA immediately take whatever action is reasonable to protect the health, safety and security of any behavioral health recipient, complainant or witness.
6. Grievances or requests for investigation must be submitted to GREABHA orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause..
7. Any GREABHA employee or contracted staff or subcontracted provider, will, upon request, assist a person receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the person to the CC or G&AA who will assist the person to file a grievance or request for investigation.
8. The G&AA will submit the complaint form and all subsequent correspondence concerning the case to the ADHS/DBHS Office of Grievance and Appeals (OGA), including: whether the person who is the subject of the grievance or request for investigation is a person who needs special assistance, and a report of any corrective action taken as a result of the findings of the investigation.
9. Preliminary Disposition
    a. Summary Disposition – Within 7 days of receiving a grievance or request for investigation, the G&AA may summarily dispose of a grievance or request for investigation when the alleged violation occurred more than one year prior to the date of request or the request can be fairly and efficiently addressed through the service planning or appeal process.
    b. Disposition without investigation – Within 7 days of receiving a grievance or request for investigation, the G&AA may resolve the matter without conducting an investigation when: there is no dispute of the facts alleged in the grievance or request for investigation or; the allegation is frivolous, as defined in the ADHS/DBHS Policy & Procedure Manual.
    c. Preliminary Disposition Response – Within 7 days of a grievance or request for investigation, the G&AA will prepare a written dated decision explaining the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution. The written decision contains a notice of appeal rights, and information to request assistance from the ADHS/DBHS Office of Human Rights and State Protection and Advocacy System. Copies of the decision are sent to the person filing the grievance or request for investigation and to the ADHS/DBHS Office of Human Rights for persons who need special assistance.

10. Investigation – A request for an extension made by a GREABHA appointed investigator will be addressed to the G&AA. If the person who is the subject of the investigation needs special assistance, the investigator shall contact the person's advocate, or if no advocate is assigned, the ADHS/DBHS Office of Human Rights, and request that an advocate be present to assist the person during the interview and investigation process.
11. The investigator prepares a written report that contains at a minimum: a summary for each person interviewed of information provided by the person during the interview; a summary of relevant information found in documents reviewed; and recommended actions or recommendation for required corrective action, if indicated.
12. Within 5 days of receipt of the investigator's report, the G&AA reviews the investigation case record, and the report, and issues a written, dated decision which either:
    a. Accepts the report and state a summary of findings and conclusions and any action or corrective action required of GREABHA and sends copies of the decision, subject to ADHS/DBHS confidentiality requirements to the investigator, GREABHA CEO, the person who filed the grievance, the person receiving services identified as the subject of the violation or abuse (if different), and the ADHS/DBHS Office of Human Rights for persons in need of special assistance. The decision sent to the grievant and person who is the subject of the grievance (if different) includes a notice of the right to request an administrative appeal of the decision within 30 days. The decision is sent to the grievant by certified mail or hand delivered.
    b. Rejects the report for insufficiency of facts and returns the matter for further investigation. The investigator must complete the further investigation and deliver a revised report to the ADHS/DBHS Deputy Director and GREABHA's CEO within 10 days.
13. The GREABHA CEO may identify actions to be taken, which may include: Identifying training or supervision for or disciplinary action against an individual found to be responsible for a rights violation or condition requiring investigation; developing or modifying a mental health agency's practices or protocols; notifying the regulatory entity that licensed or certified an individual of the findings from the investigation; or imposing sanctions.
14. Provider Claims Dispute Resolution Process

Claim Disputes of decisions made by GREABHA or GREABHA providers will be addressed by CBH. CBH's Medical Review Unit (MRU) is part of the CBH Claims Department, and is responsible for ensuring that provider claims disputes are processed, tracked and resolved within ADHS/DBHS timeframes and requirements.

All documentation received during the claim dispute resolution process is date stamped upon receipt. All claim dispute case records are filed in secured locations and retained for five years after the final decision. All decisions will be personally delivered or mailed by certified mail to all parties at their last known residence or place of business. Our providers will be notified of GREABHA's delivery/mailing address for the receipt of claim disputes filed during provider orientations, provider manual, and EOP's. When a claim for payment is denied in whole or in part, CBH notifies the affected provider in writing of the right to file a claim dispute. A unique ADHS/DBHS Docket Number for each claim dispute filed will be established including: the ADHS/DBHS or T/RBHA letter code; the date of receipt of the claim dispute; the letter code "P" designating the case as a claim dispute; and a four-digit sequential number, which begins on 01/01 of each year.

The CC will enter all information into the ADHS/DBHS Office of Grievance and Appeals database related to the claim dispute resolution process necessary for the accurate and timely maintenance of the log, including: A unique ADHS/DBHS Docket Number; A substantive, concise description of the dispute and whether the claim dispute is related to the provision of Title XIX or Title XXI covered services; date of the claim being disputed; date the request for claim dispute resolution was received; nature, date, and outcome of all subsequent decisions, appeals, or other

relevant events; and a substantive, concise description of the final decision, the action taken to implement the decision and the date the action was taken.

A Claim Dispute relating to the imposition of a sanction will be initiated within 60 days from the date of the notice advising that a sanction will be imposed. A claim dispute relating to the denial of a claim for payment in whole or part, or of non-payment of a claim, must be initiated within 12 months of the date of the service delivery; 12 months after the date of eligibility posting; or within 60 days after the date of a timely claim submission, whichever is later.

For Claim Disputes of ADHS/DBHS or Tribal RBHA decisions that ADHS/DBHS determines arise out of a decision made by GREABHA or our provider, the claim dispute will be forwarded to CBH and the above procedures followed per ADHS/DBHS policy. A copy of the transmittal shall also be sent by ADHS/DBHS to the party filing the claim dispute. CBH will render a decision within 30 days of receipt of the notice of claim dispute unless an extension has been granted per ADHS/DBHS policy and send written notification to the Deputy Director of ADHS/DBHS who will issue a written decision to the party filing the claim dispute within 30 days of receipt of the dispute. The notification will include a statement of the right to request an administrative hearing by filing a request with the ADHS/DBHS Office of Grievance and Appeals ADHS/DBHS, within 30 days of receipt of the decision and a description of the provider's right to request an informal settlement conference.

For Claim Disputes of GREABHA decisions Within 5 days of receipt of a claim dispute of GREABHA decisions, the director of GREABHA shall send written acknowledgment that the claim dispute has been received, will be reviewed and that a decision will be issued within 30 days of receipt of the claim dispute. If GREABHA determines that it was not responsible for the claim dispute, GREABHA shall immediately forward the claim dispute to ADHS/DBHS for processing and resolution with an explanation of why the claim dispute is being forwarded and will also send a copy of the transmittal to the party filing the claim dispute. If the party filing a claim dispute is dissatisfied with the ADHS/DBHS Deputy Director's or GREABHA director's decision, or if a written Notice of Decision is not received within 30 days after the claim dispute is filed, a request for administrative hearing may be filed with the ADHS/DBHS Office of Grievance and Appeals.

Tracking, Analyzing, and Reporting Complaint Data

The Complaint Coordinator tracks complaints/grievances according to the following categories:

- Access
- UM, Claims
- Attitude or Quality of Service
- Quality of Care
- Benefit/Plan Admin

Each category is divided into subcategories to further delineate who the complaint is against or what the complaint is about, for example: Quality of Service may relate to any of the following: PSR, CSR, UM, Provider, Management, Provider Relations or Quality of Care may relate to practice providers, network providers, treatment protocols or attitude.

The Quality Management department prepares and submits a monthly summary report and analysis of complaint activity to the QMC. The QMC and GREABHA's Consumer Board then review the complaint data and analysis, and make recommendations as necessary to better serve consumers and clients.

b.4) Grievance and Appeals Rights

GREABHA ensures that grievance and appeals rights are clearly communicated and understood by behavioral health recipients in the following formal and informal ways:

Formal ways of ensuring that grievance and appeals rights are clearly communicated and understood:

- Day-to-day Operations: Behavioral health recipients are assisted whenever they call in or come into contact with a GREABHA employee and if there is indication of dissatisfaction with the program, our staff or their provider. All GREABHA employees are required to confirm that a consumer knows their rights to file a formal or informal complaint and will assist them by documenting the concerns and submitting those to the Complaint Coordinator by the next business day.
- Consumer Outreach Calls: These are made to all eligible recipients within 90 days of becoming eligible for services. Members receive information on grievance and appeals rights in addition to information about how to access care, how the program works and contact information. Recipients are given an opportunity to ask questions and express any concerns about the program.
- Consumer/family intake process: GREABHA works with provider agencies to ensure that they give consumers and family members' information on definitions of and how to file a complaint, grievance or appeal along with contact information and sample forms for filing, as part of the behavioral health intake process.
- Written notices of denials, reductions of terminations in services, which explain in everyday language how to file a compliant, grievance and appeal
- Consumer Handbook: Distributed within 10 days of receiving a first service. The handbook will also be available on our website.
- Intake by provider agencies: GREABHA requires providers to post notices, as required by regulations, informing enrollees and subscribers how to resolve problems with their health care service.

Informal ways of ensuring that grievance and appeals rights are clearly communicated and understood:

- Consumer Satisfaction Surveys: These will include a question related to whether or not grievance and appeals rights are being communicated, and are easily understood.
- Consumer Council Meetings: Reviews these rights whenever concerns or dissatisfaction is raised, and staff will be available to assist in filing of formal complaints, should consumers request to do so. All comments are documented and action steps determined for resolution or review of concerns related to the program as a whole; consumers attending these meetings are also reminded of their right to follow up individually on specific issues of concern through the formal grievance and appeals process.
- Provider orientations/manual: Includes grievance and appeals information to share with members and are required to do so for any denial of service. Providers are required, by contract, to assist members with filing complaints and the provider manual outlines their responsibility to do so.
- Web based information: Information for both members and providers on rights to file complaints, grievances and appeals along with an online form for submission via the Internet.

Consumers with Special Needs

CBH is committed to ensuring that every consumer understands his/her complaint and his/her grievance and appeals rights, regardless of educational or cultural background, cognitive ability, visual, hearing or other limitations. To that end, we provide the following:

- Oral interpretation services free of charge for all persons with Limited English Proficiency (LEP)
- Written materials at the 6th grade educational level and available in Braille and Large Font
- Written materials related to grievance and appeals translated into another language whenever CBH identifies that 1,000 persons or 5% of the population (whichever is less) speak the other language and have LEP
- TDD/TDY lines for those with hearing limitations
- Materials available in alternative formats for the visually impaired, such as audio tapes.